**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.13(2)

F-11133 (08/2017)

**FORWARDHEALTH**

**PERSONAL CARE SCREENING TOOL (PCST)**

**Instructions:** Print or type clearly. Refer to the Personal Care Screening Tool (PCST) Completion Instructions, F-11133A, for information on completing this form.

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| **SECTION I – BASIC INFORMATION – SCREENER** | | | |
| 1a. Name – Screening Agency | | | 2. Screen Completion Date |
| 1b. Telephone Number – Screening Agency | | |
| 3a. Name – Screener (First Name, Middle Initial, Last Name) | | | |
| 3b. Qualifications – Screener  Registered Nurse (RN)  Certified Adult LTC Functional Screener  Other | | | |
| **SECTION II – BASIC INFORMATION – MEMBER** | | | |
| 4. Name and Title – Member (Title, First Name, Middle Initial, Last Name [Middle Initial and Title Optional]) | | | |
| 5. Gender – Member  Male  Female | 6. Date of Birth – Member | 7. Social Security Number – Member\ | |
| 8. Living Situation – Member  **Own Home or Apartment**  Alone; includes person living alone who receives in-home services  With spouse / partner / family  With nonrelative / roommates; includes dormitory, convent, or other communal setting  With live-in paid caregiver(s); includes service in exchange for room and board  **Someone Else’s Home or Apartment**  Family  Nonrelative  1-2 bed adult family home (certified) or other  Paid caregiver’s home  Home / apartment for which lease is held by support services provider  **Apartment with Services**  Residential care apartment complex  Independent apartment community-based residential facility  **Group Residential Care Setting**  Licensed adult family home (three to four-bed home)  Community-based residential facility with 1-20 beds  Community-based residential facility with more than 20 beds  Children’s group home  **Health Care Facility / Institution**  Nursing home; includes rehabilitation facility  Intermediate care facility for individuals with intellectual disabilities  Developmental disability center / state institution for developmental disabilities  Mental health institute / state psychiatric institution  Other institution for mental disease  Child caring institution  Hospice  No permanent residence (e.g., a homeless shelter)  **Other**  Specify (e.g., jail) | | | |

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| **SECTION II – BASIC INFORMATION – MEMBER (Continued)** | | |
| 9. Address – Member (Street, City, State, ZIP Code) | | |
| 10. Telephone Number – Member (Optional)  Home       Work       Cell | | |
| 11. County / Tribe of Residence – Member | | 12. County / Tribe of Responsibility – Member |
| **SECTION III – INSURANCE AND CONTACT INFORMATION – MEMBER** | | |
| 13. Medical Insurance  Check all that apply:  Medicare (Specify ID number.)  Part A Effective Date (If known.)  Part B Effective Date (If known.)  Medicare Managed Care  ForwardHealth (Specify member number.)  Private insurance (Includes employer-sponsored [job benefit] insurance)  Private Long-Term Care Number  Railroad Retirement (Specify number.)  Other insurance  No medical insurance at this time | | |
| 14. Responsible Party Contact if Not "Member" (Optional)  Adult Child  Power of Attorney  Ex-spouse  Sibling  Guardian of Person  Spouse  Parent / Stepparent  Other Informal Caregiver / Support | | |
| 15. Name – Responsible Party (First, Middle Initial, Last)  (Optional) | 16. Telephone Number(s) – Responsible Party (Optional)  Home  Work  Cell  Best time to call | |
| 17. Address – Responsible Party (Street, City, State, ZIP Code) (Optional) | | |

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| **SECTION IV – ACTIVITIES OF DAILY LIVING** |
| 18. Scheduled Activities Outside the Residence (Include a schedule of activities in the member’s medical file.)  Does the member regularly attend scheduled activities outside the residence?  Yes  No  If yes, how many days per week do regularly scheduled activities occur? |
| 19. Bathing  “Bathing” means cleansing **all** surfaces of the body and includes assistance with changing clothing, getting in and out of the tub or shower, wetting, soaping, and rinsing skin, shampooing hair, drying body, applying lotion to skin, applying deodorant, and routine catheter care. Do not select bathing for activities that are grooming, washing hands and face only, and clean-up following incontinence and meals.  Select the response, A–F, that best describes the level of function the member possesses when bathing.  A. Member is able to bathe him- or herself in the shower or tub, with or without an assistive device.  B. Member is able to bathe him- or herself in the shower or tub but requires the presence of another person intermittently for supervision or cueing.  C. Member is able to bathe him- or herself in shower or tub but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task. Complete Comments below if "C" is selected.  D. Member is able to bathe in shower, tub, or bed with partial physical assistance from another person.  E. Member is unable to effectively participate in bathing and is totally bathed by another person.  F. Member’s ability is age appropriate for a child age 5 or younger.  Indicate the number of days per week personal care worker (PCW) assistance is medically necessary with bathing:  Comments (Required if Bathing "C" is selected.) |
| 20. Dressing  “Dressing” means the ability to dress and undress (with or without an assistive device). Dressing assistance does not include activities with garment closures (e.g., zippers, buttons) at the back of the garment. Typical clothing changes are from sleepwear to daywear and from daywear to sleepwear.  **Upper Body**  Upper body dressing includes dressing activities related to garments covering the torso above the waist (e.g., shirt, sweater, pajama top, T-shirt, and dress). Select the response, A-F that best describes the level of function the member possesses when dressing his or her upper body.  A. Member is able to dress the upper body without assistance or is able to dress him- or herself if clothing is laid out or handed to him or her.  B. Member is able to dress the upper body by him- or herself but requires the presence of another person intermittently for supervision or cueing.  C. Member is able to dress the upper body by him- or herself but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task. Complete Comments below if "C" is selected.  D. Member needs partial physical assistance from another person to dress the upper body.  E. Member depends entirely upon another person to dress the upper body.  F. Member’s ability is age appropriate for a child age 5 or younger.  Indicate when PCW assistance with dressing the upper body is medically necessary.  A.M.  P.M.  Both  Indicate the number of days per week PCW assistance with dressing the upper body is medically necessary.  Comments (Required if Dressing Upper Body "C" is selected.) |

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| **SECTION IV – ACTIVITIES OF DAILY LIVING (Continued)** |
| 20. Dressing (Continued)  **Lower Body**  Lower body dressing includes dressing activities related to garments covering the torso from the waist down (e.g., pants, underpants, skirt, socks, and shoes). Select the response, A–F that best describes the level of function the member possesses when dressing his or her lower body.  A. Member is able to dress the lower body without assistance or is able to dress him- or herself if clothing is laid out or handed to him or her.  B. Member is able to dress the lower body by him- or herself but requires the presence of another person intermittently for supervision or cueing.  C. Member is able to dress lower body by him- or herself but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task. Complete Comments below if "C" is selected.  D. Member needs partial physical assistance from another person to dress the lower body.  E. Member depends entirely upon another person to dress the lower body.  F. Member’s ability is age appropriate for a child age 5 or younger.  Indicate when PCW assistance with dressing the lower body is medically necessary.  A.M.  P.M.  Both  Indicate the number of days per week PCW assistance with dressing the lower body is medically necessary.  Comments (Required if Dressing Lower Body "C" is selected.) |
| 21. Prescription Prosthetics, Braces, Splints, and/or Anti-Embolism Hose  Indicate whether or not PCW assistance is needed with placement and/or removal of a prescribed Medicaid covered prosthetic, brace, splint, or anti-embolism hose if medically necessary. If "Yes" is selected, indicate which item(s) the PCW is placing and/or removing in the Comments below.  Yes  No  Indicate the number of days per week PCW assistance with placement and/or removal of a prescribed Medicaid-covered prosthetic, brace, splint, or anti-embolism hose is medically necessary.  Comments (Required if "Yes" is selected.) |
| 22. Grooming  “Grooming” means the ability to tend to personal hygiene needs. Grooming activities include washing face, hands, and feet; combing, brushing, and shampooing hair; shaving; nail care; applying deodorant; and oral or denture care. Grooming should not be selected for activities (e.g., shampooing or deodorant application) that can be completed during bathing.  Select the response, A–G, that best describes the level of function the member possesses when grooming.  A. Member is able to groom him- or herself, with or without the use of assistive devices or adapted methods.  B. Member is able to groom him- or herself but requires the presence of another person intermittently for supervision or cueing.  C. Member is able to groom him- or herself but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task. Complete Comments below if "C" is selected.  D. Member needs physical assistance to set up grooming supplies, but can groom him- or herself.  E. Member needs partial physical assistance to groom him- or herself.  F. Member depends entirely upon another person for grooming.  G. Member’s ability is age appropriate for a child age 5 or younger.  Indicate when PCW assistance with grooming is medically necessary.  A.M.  P.M.  Both  Indicate the number of days per week PCW assistance is needed with grooming.  Comments (Required if Grooming "C" is selected.) |

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| **SECTION IV – ACTIVITIES OF DAILY LIVING (Continued)** |
| 23. Eating  “Eating” means the ability to use conventional or adaptive utensils to ingest meals by mouth. Do not select "eating" if only assistance with meal preparation is needed. Time for meal preparation is included with time for services incidental to activities of daily living (ADL). Refer to Element 30 for time for meal preparation.  Select the response, 0 or A–H, that best describes the level of function the member possesses when eating. Complete the daily tube feedings under Element 29 as appropriate.  0. Member's nutritional needs are met primarily through tube feedings or intravenously.  A. Member is able to feed him- or herself, with or without use of assistive device or adapted methods.  B. Member is able to feed him- or herself but requires the presence of another person intermittently for supervision or cueing.  C. Member is able to feed him- or herself but requires physical assistance at meal time with set up.  D. Member is able to feed him- or herself but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task. Complete Comments below if "D" is selected. Do not select "D" for a member who requires monitoring to assure the member does not overeat or "play" with food or for a member who requires a special diet.  E. Member has recent history of choking or potential for choking, based on documentation. Complete Comments below if "E" is selected. Include in the comments the supporting medical diagnosis and the reason this level of assistance from a PCW is medically necessary.  F. Member needs partial physical feeding from another person.  G. Member needs total feeding from another person.  H. Member’s ability is age appropriate for a child age 3 or younger.  Indicate the meals for which PCW assistance is medically necessary.  Breakfast  Lunch  Dinner  None  Indicate the number of days per week PCW assistance is medically necessary for each meal.  Breakfast       Lunch       Dinner        Not Required  Comments (Required if Eating "D" or "E" is selected.) |
| 24. Mobility in the Home  “Mobility in the home” means the ability to move about (ambulate) the member’s living environment, including the kitchen, living room, bathroom, and sleeping area. **This excludes basements, attics, yards, and any equipment used outside the home.**  Select the response, 0 or A–E, that best describes the level of function the member possesses when moving between locations in the home with or without help from an assistive device. Assistive devices include, but are not limited to, canes, crutches, walkers, scooters, and wheelchairs.  0. Member remains bedfast.  A. Member is able to move about by him- or herself.  B. Member is able to move about by him- or herself but requires the presence of another person intermittently for supervision or cueing.  C. Member is able to move about by him- or herself but requires the constant presence of PCW to provide immediate physical intervention during the performance of the task. Complete Comments below if "C" is selected.  D. Member needs physical help from another person.  E. Member’s ability is age appropriate for a child 18 months or younger.  Indicate the number of days per week PCW assistance is medically necessary with mobility in the home.  Comments (Required if Mobility in the Home "C" is selected.) |

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| **SECTION IV – ACTIVITIES OF DAILY LIVING (Continued)** |
| 25. Toileting  Toileting includes transfers on and off the toilet or other container for collection of waste, cleansing affected body surfaces, changing personal hygiene products used for incontinence, emptying an ostomy or catheter bag, and adjusting clothes. Toileting includes all transfers related to toileting.  Select the responses, A–G, that best describe the level of function the member possesses when toileting. Select all responses that applyand, as requested, include the frequency per day.  A. Member is able to toilet him- or herself or provide his or her own incontinence care, with or without an assistive device.  B. Member is able to toilet him- or herself or provide his or her own incontinence care, with or without an assistive device but requires the presence of another person intermittently for supervision or cueing.  C. Member is able to toilet him- or herself or provide his or her own incontinence care but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task.  Estimated frequency per day that PCW assistance is needed with toileting.  Complete Comments below if "C" is selected.  D. Member needs physical help from another person to use the toilet and/or change a personal hygiene product.  Estimated frequency per day that PCW assistance is needed with toileting.  E. Member needs physical help from another person for incontinence care. (Does not include stress incontinence.)  Estimated frequency per day that PCW assistance is needed with incontinence care.  F. Member needs physical help from another person to empty an ostomy or catheter bag.  Estimated frequency per day that PCW assistance is needed with ostomy or catheter care.  G. Member’s ability is age appropriate for a child age 4 or younger.  Indicate the number of days per week PCW assistance is medically necessary for toileting.  Comments (Required if Toileting "C" is selected.) |
| 26. Transferring  “Transferring” means physically moving from one surface to another (e.g., from bed to wheelchair and from scooter to bed or usual sleeping place) and the ability to use assistive devices for simple transfers. Complete "Other" in Element 29 for all complex transfers. Transferring excludes transfers related to bathing and toileting.  Select the response, A–G, that best describes the level of function the member possesses when transferring.  A. Member is able to transfer him- or herself, with or without an assistive device.  B. Member is able to transfer him- or herself, with or without an assistive device, but requires the presence of another person intermittently for supervision or cueing.  C. Member is able to transfer him- or herself, with or without an assistive device, but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task and provide physical intervention for at least one step of the activity during the performance of the task. Complete Comments if "C" is selected.  D. Member needs the physical help of another person but is able to participate (e.g., member can stand and bear weight).  E. Member needs constant physical help from another person and is unable to participate (e.g., member is unable to stand and pivot or is unable to bear weight).  F. Member needs help from another person with the use of a mechanical lift (e.g., Hoyer) when transferring. Complete “Other” in Element 29 if “F” is selected in this element.  G. Member’s ability is age appropriate for a child age 3 or younger.  Indicate the number of days per week PCW assistance is needed with transferring.  Comments (Required if Transferring "C" is selected.) |

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| **SECTION V – MEDICALLY ORIENTED TASKS – DELEGATING NURSING ACTS** |
| 27. (**Part I**) Medication Assistance Delegated to a PCW  Select the option that best describes the member's level of need for PCW assistance with prescription medications that are usually self-administered. (Do not include giving injections.)  0. Not applicable  A. Independent with medications, with or without the use of a device  B. Needs reminders  C. Needs the physical help of another person, not a PCW  D. Needs the physical help of a PCW  Frequency per day  Indicate the number of days per week PCW assistance is needed with medication assistance.  Comments |
| 28. (**Part II**) Delegated Nursing Acts to Be Performed by a PCW  Select the tasks to be completed by a PCW. Indicate the frequency per day and days per week each task will be performed.  Glucometer Readings (Allowed when medical condition supports the need for ongoing, frequent monitoring for the early detection of glucose readings outside parameters established by the physician.)  PCW Frequency Per Day       PCW Days Per Week  Skin Care (Application of prescription medications. Do not include application of dressings involving prescription medication and use of aseptic techniques.)  Name of Prescription Medication (Required if Skin Care is selected.)  Frequency Prescribed (Required if Skin Care is selected.)  PCW Frequency Per Day       PCW Days Per Week  Catheter Site Care (Only for suprapubic catheters. Do not include insertion and sterile irrigation of catheters.)  PCW Frequency Per Day       PCW Days Per Week  Feeding Tube Site Care (Do not select if the site care needed is only cleansing with soap and water.)  PCW Frequency Per Day       PCW Days Per Week  Complex Positioning  PCW Frequency Per Day       PCW Days Per Week  Comments |

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| **SECTION V – MEDICALLY ORIENTED TASKS – DELEGATING NURSING ACTS (Continued)** |
| 29. (**Part III**) Delegated Nursing Acts to Be Performed by a PCW **(ForwardHealth review and manual approval may be required.)**  Select the tasks to be completed by a PCW as delegated by the RN. Indicate the frequency per day and days per week each task will be performed. For tasks indicated in this element, manual review of the prior authorization (PA) request will be required only when the total amount of time computed by the PCST is insufficient for a PCW also to provide the delegated medical tasks identified in this element **and** additional time is being requested for those delegated medical tasks. Include the Personal Care Addendum, F-11136, the plan of care (POC), and other documentation as directed when submitting the PA request.  **Daily Tube Feedings (Nasogastric, Gastrostomy, or Jejunostomy)**  Continuous Feeding PCW Frequency Per Day       PCW Days Per Week  Intermittent (Bolus) Feeding PCW Frequency Per Day       PCW Days Per Week  **Respiratory Assistance (Check all that apply.)**  Tracheostomy Care PCW Frequency Per Day       PCW Days Per Week  Suctioning PCW Frequency Per Day       PCW Days Per Week  Chest Physiotherapy PCW Frequency Per Day       PCW Days Per Week  Nebulizer PCW Frequency Per Day       PCW Days Per Week  **Bowel Program (Check all that apply.)**  Suppository PCW Frequency Per Day       PCW Days Per Week  Enema PCW Frequency Per Day       PCW Days Per Week  Digital Stimulation PCW Frequency Per Day       PCW Days Per Week  **Other Program (Check all that apply.)**  **Wound Care** (Excludes basic skin care. Do not include application of dressings involving prescription medication and use of aseptic techniques.)  PCW Frequency Per Day       PCW Days Per Week  **Range of Motion** (Ordered by a physician but not part of a prescribed therapy program.)  PCW Frequency Per Day       PCW Days Per Week  **Vital Signs** (Allowed when medical condition supports the need for ongoing, frequent monitoring for early detection of an exacerbation of the existing medical condition, the physician has established parameters, and readings outside the established parameters will trigger a medical intervention or change in treatment.)  PCW Frequency Per Day       PCW Days Per Week  **Other (Specify all tasks that apply.)**  PCW Frequency Per Day       PCW Days Per Week        PCW Frequency Per Day       PCW Days Per Week  Comments (Required for all delegated nursing acts selected in Part III except Vital Signs.) |

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| **SECTION VI – OTHER CONSIDERATIONS** |
| 30. Will services incidental to the ADL and delegated nursing acts be performed by the PCW?  Services incidental to ADL and delegated nursing acts include changing the member’s bed, laundering the member’s bed linens and personal clothing, care of eyeglasses (also contact lenses) and hearing aids, light cleaning in essential areas of the home used during personal care services, purchasing food for the member, preparing the member’s meals, and cleaning the member’s dishes. (Refer to the Personal Care area of the Online Handbook on the ForwardHealth Portal.)  Yes  No |
| 31. Behaviors  Does the member exhibit more often than once per week behavior that interferes with the PCW's assistance with ADL and delegated nursing acts and makes ADL and delegated nursing acts more time consuming for the PCW to complete?  Yes  No  If “Yes,” list the behavior(s) and describe how the behavior(s) interferes and makes the ADL and delegated nursing acts more time consuming for the PCW to complete. |
| 32. Medical Conditions  Does the member have a rare medical condition that makes ADL and delegated nursing acts more time consuming for a PCW to complete, which is expected to result in a long-term need for extra time?  Yes  No  If “Yes,” list the rare medical condition(s), the diagnosis code, the protective equipment prescribed for the member (if any), and member-specific precautions (if any) the PCW is required to adhere to in order to accommodate the rare medical condition, and describe how the condition makes the ADL and delegated nursing acts more time consuming for the PCW to complete. |
| 33. Seizures  Does the member have a diagnosis of seizures?  Yes  No  If “Yes,” complete the following.  Date of Last Seizure  A. 0–90 days ago  B. 91–180 days ago  C. More than 180 days ago  Specific Seizure Type  Frequency of Seizures  Date of Last Seizure  Does the PCW provide interventions?  Yes  No  If “Yes,” list interventions. |

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| **SECTION VI – OTHER CONSIDERATIONS (Continued)** | | | |
| 34. Pro Re Nata (PRN)  When the member goes to Medicaid-covered appointments and/or if the member is expected to experience short duration episodes of acute need, will the PCW assist with ADLs and/or perform delegated nursing acts as indicated in the POC?  Yes  No | | | |
| 35. Notes  Enter information that will enhance the nurse consultant's understanding of the member's medical condition and need for PRN time. | | | |
| **SECTION VII – REQUIRED PCST SUMMARY SHEET COMPLETION INFORMATION** | | | |
| 36. Name – Billing Provider | | | 37. Billing Provider Number |
| Check if case sharing. | Names – Other Agencies Sharing the Case | |
| 38. Address – Billing Provider (Street, City, State, ZIP+4 Code) | | | |
| **SECTION VIII – SIGNATURE** | | | |
| As the authorized screener completing this PCST, I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form. | | | |
| 39. **SIGNATURE** – Authorized Screener | | 40. Date Signed – Authorized Screener | |